RSC Republican Study Committee
Rep. Jeb Hensarling (R-TX), Chairman
Russ Vought, Executive Director
132 Cannon House Office Building
Washington, DC 20515
www.house.gov/hensarling/rsc
ph (202) 226-9717 / fax (202) 226-1633

RSC Policy Brief:
Medicare Advantage

June 2, 2008

The RSC has prepared the following policy brief summarizing the history and status of the Medicare Advantage program and offering suggestions for its improvement.

History and Background: For several decades, Medicare has utilized private insurers as one option for beneficiaries to receive health care coverage. In 1997, the Balanced Budget Act (BBA) created a new Medicare+Choice program intended to control the growth of health care costs and eliminate regional variations in payment and spending levels. In 2003, the Medicare Modernization Act (MMA) converted the Medicare+Choice program into its current form as Medicare Advantage (MA).

Bids and Benchmarks: The MMA made several changes to the bidding and payment structure for private Medicare Advantage plans to deliver health care to beneficiaries. As currently constructed, plans receive capitated monthly payments that are subject to risk adjustment—so that plans caring for older, sicker beneficiaries receive higher payments than those with healthier populations. In order to determine the capitated payment amount, plans submit annual bids to the Centers for Medicare and Medicaid Services (CMS). The bids are compared against a benchmark established by a detailed formula—but the comparison against the benchmark does not directly allow plans to compete against each other, or against traditional Medicare, when CMS evaluates plan bids.

In the event a plan's bid is below the annual benchmark, 75% of the savings is returned to the beneficiary in the form of lower cost-sharing (i.e. premiums, co-payments, etc.) or better benefits, with the remaining 25% returned to the federal government. If a plan's bid is above the benchmark, beneficiaries pay the full amount of any marginal costs above the benchmark threshold.

Benefits and Services Provided: Most Medicare Advantage plans use rebates provided when bidding below the benchmark to cover additional services over and above those provided by traditional Medicare, and in so doing reduce beneficiaries' exposure to out-of-pocket costs. A Government Accountability Office (GAO) report released in February 2008 documented that in most cases, beneficiaries receive better benefits under Medicare Advantage than they would under traditional Medicare. The GAO study found that beneficiary cost-sharing would be 42% of the amounts anticipated under traditional Medicare, with beneficiaries saving an average of $67 per month, or $804 annually.[1] These savings to MA beneficiaries occurred because plans dedicated 89% of their rebates from low bids to reduced cost-sharing or lower premiums. The remaining 11% of rebates were used to finance additional benefits, such as vision, dental, and hearing coverage, along with various health education, wellness, and preventive benefits.[2] Due in part to the increased benefits which Medicare Advantage plans have provided, enrollment in MA plans is estimated to rise to 22.3% of all Medicare beneficiaries in 2008, up from 12.1% in 2004.[3]

Medicare Advantage "Overpayments": Some independent studies have suggested that Medicare Advantage plans incur higher costs than the average annual cost of providing coverage through traditional Medicare, though estimates vary as to the disparity between the two forms of coverage. However, to the extent that MA plans in fact receive payments in excess of the costs of traditional Medicare, this discrepancy remains inextricably linked to two features of the Medicare Advantage program—the increased benefits for beneficiaries, and the complexity of the MA plan bidding mechanism. Because of the problems inherent in the statutory benchmark design, plans have little incentive to submit bids less than the cost of traditional Medicare, as plans that bid above the costs of traditional Medicare but below the benchmark receive the difference between traditional Medicare costs and the plan bid as an extra payment to the plan.[4]

Last July, House Democrats attempted to "fix" the MA overpayments by passing H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act. Section 401 of the legislation proposed to set Medicare Advantage payments at 100% of the costs of traditional Medicare. Despite the flaws in the bidding process discussed above, many conservatives opposed the Democrats' proposal as an attempt to restrict beneficiary choice to private health insurance options by placing arbitrary restrictions on Medicare Advantage plans. The Senate has not taken up the measure, which President Bush threatened to veto.

Some conservatives would also argue that a discussion focused solely on Medicare Advantage "overpayments" ignores the significant benefits that MA plans provide to key underserved beneficiary populations. Medicare Advantage plans have expanded access to coverage in rural

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[1] Government Accountability Office, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs," (Washington, Report GAO-08-359, February 2008), available online at http://www.gao.gov/new.items/d08359.pdf (accessed May 19, 2008), p. 23.
[2] Ibid., pp. 17-20.
[3] Department of Health and Human Services, "HHS Budget in Brief: Fiscal Year 2009," available online at http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf (accessed May 19, 2008), p. 58.
[4] The Medicare Payment Advisory Commission (MedPAC) has alleged that the formula-driven benchmarks themselves exceed the cost of traditional Medicare. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, DC, March 2008), available online at http://www.medpac.gov/documents/Mar08_EntireReport.pdf (accessed May 9, 2008), Table 3-3, p. 247.

areas. Moreover, the disproportionate share of low-income and minority populations who have chosen the MA option suggests that the comprehensive benefits provided are well-suited to beneficiaries among vulnerable populations. Data from the Medicare Current Beneficiary Survey demonstrate that almost half (49%) of Medicare Advantage beneficiaries have incomes less than $20,000, and that 70% of Hispanic and African-American Medicare Advantage enrollees had incomes below the $20,000 level.[5] For this reason, both the National Association for the Advancement of Colored People and the League of United Latin American Citizens opposed the cuts proposed by House Democrats as part of H.R. 3162.[6]

Reform Options: To the extent that private plans are paid more than traditional Medicare for beneficiary care, some conservatives would argue that this concern is a symptom of the larger problems in Medicare Advantage bidding procedures—where ***more competition***, not government-imposed price controls that arbitrarily reduce "overpayments," would provide the most effective route to reforming Medicare.

Prime among the reform options would be a pure premium support model—one that would allow Medicare Advantage plans to bid against each other (as they do in the Part D prescription drug benefit), and against traditional Medicare. This model would convert Medicare into a system similar to the Federal Employees Benefit Health Plan (FEHBP), in which beneficiaries would receive a defined contribution from Medicare to purchase a health plan of their choosing. Previously incorporated into alternative RSC budget proposals, a premium support plan would provide a level playing field between traditional Medicare and private insurance plans, providing comprehensive reform, while confining the growth of Medicare spending to the annual statutory raise in the defined contribution limit, thus ensuring long-term fiscal stability.

Additional policy changes to improve Medicare Advantage could eliminate the inbuilt bias towards traditional Medicare by reforming the beneficiary enrollment model and expanding consumer-driven Medicare Advantage plans. Current law provides an inherent bias towards traditional Medicare, by automatically enrolling beneficiaries in the government-run plan; beneficiaries must take an affirmative measure to enroll in an alternative Medicare Advantage plan. However, some conservatives may support measures that would auto-enroll beneficiaries in randomly assigned plans—both traditional Medicare and private Medicare Advantage plans—below a certain cost threshold, as occurs for dual-eligible beneficiaries randomly assigned to Part D prescription drug plans. Some conservatives may also support reforms to Medicare Medical Savings Accounts (MSAs) that would make them more attractive to beneficiaries, providing additional incentives for seniors to become more cost-conscious when considering health care treatment options.

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[5] America's Health Insurance Plans, "Low Income and Minority Beneficiaries in Medicare Advantage Plans," (Washington, DC, AHIP Center for Policy and Research, February 2007), available online at http://www.ahipresearch.org/PDFs/FullReportAHIPMALowIncomeandMinorityFeb2007.pdf (accessed May 19, 2008), p. 3.

[6] "Minority Groups Oppose Proposed Reduction in Funds for Medicare Advantage Plans," *Kaiser Daily Health Policy Report* March 16, 2007 (Washington, DC: Henry J. Kaiser Family Foundation), available online at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=43645 (accessed May 9, 2008).

Conclusion: The Medicare funding warning issued by the trustees last year, and again this year, provides an opportunity to re-assess the program's structure and finance. These two consecutive warnings—coupled with the trustees' estimate that the Medicare trust fund will be exhausted in just over a decade's time—should prompt Congress to consider ways to reduce the growth of overall Medicare costs, particularly those which utilize competition and consumer empowerment to create a more efficient and cost-effective Medicare program.

Over and above the significant benefits which Medicare Advantage plans have provided to millions of beneficiaries, some conservatives may believe that private MA plans have the potential to reform Medicare and ultimately slow its overall spending levels. Although introduction of a prescription drug benefit has significantly increased Medicare's unfunded obligations in absolute terms, the fact that competition among Part D participants has slowed the growth of its costs suggests that similar efforts to inject competition into traditional Medicare could comprise one element of comprehensive entitlement reform. As a result, many conservatives would oppose attempts by the Democrat majority to eliminate private MA plans from their important role in delivering Medicare benefits, and would instead support further reforms to streamline the MA bidding process and improve the opportunities for savings generated by competitive forces.

For further information on this issue see:

- *Medicare Advantage: The Facts*
- *RSC Policy Brief: President's Medicare "Trigger" Proposals*
- *RSC Policy Brief: Medicare Funding Warning*
- *Heritage Foundation Report: The Economic and Fiscal Effects of Financing Medicare's Unfunded Liabilities*

RSC Staff Contact: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

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